Washington State Department of Health
Public Health Laboratories

State of Washington
Department of Health
PUBLIC HEALTH LABORATORIES
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MTS #1327 CLIA #50D0661453
Http://WWW.DOH.WA.GOV/EHSPHL/PHL

SEROLOGY/VIROLOGY/HIV

FOR PHL USE ONLY

Lab Number Date/Time Received

Please Print Clearly

PATIENT

NAME (LAST)

(FIRST) (MI)

ADDRESS

CITY STATE ZIP CODE

MALE ○ FEMALE ○ DATE OF BIRTH MO DAY YR COUNTY

CHART OR PATIENT ID NUMBER PT PHONE: ( )

PHYSICIAN PHYSICIAN'S PHONE # ( ) -

SUBMITTER

NAME OF PERSON COMPLETING THIS FORM PHONE # ( ) -

MAIL RESULTS TO:

CITY, STATE, ZIP CODE:

COUNTY

AREA CODE & PHONE # ( ) - FAX # ( ) -

EPIDEMIOLOGY

H1N1 swine-origin flu testing will be done at DOH PHL only if approved by the local health jurisdiction for the following (please indicate reason):

☐Yes	Death suspected due to influenza **OR**
☐Yes	Influenza A test positive AND **one** of the following (please check): ☐ hospitalized ☐ health care worker ☐ age < 5 years ☐ age ≥ 65 years ☐ pregnant **OR**
☐Yes	Other public health reason approved by local health jurisdiction: _____

COMMENTS

SPECIMEN INFORMATION

ATTENTION: (See Instructions on Reverse Side of Form)

○ SYPHILIS SEROLOGY X VIRUS ○ HIV

SPECIFIC AGENT SUSPECTED: H1N1 (Swine Flu)

DATE COLLECTED MO DAY YR TIME OF DAY ___:___ ○ AM ○ PM

DATE OF ONSET MO DAY YR TIME OF DAY ___:___ ○ AM ○ PM

DATE SENT TO STATE MO DAY YR FATAL? ○ YES ○ NO

SUBMITTER'S LAB NUMBER:

TYPE OF SPECIMEN

○ SERUM/BLOOD ○ CSF X NP/THR ○ ORASURE

○ OTHER (SPECIFY) _____

VIRUS EXAMINATIONS

Chief Clinical Findings. (check system involved and list chiefs symptoms)

X ○ Respiratory _____

○ Central Nervous System _____

○ Cutaneous Eruptions- Location and Type _____

○ Other _____

Optimally, collect isolation specimen within 3 days of onset. Submit each specimen as soon as collected. Keep at refigerator temperatures. 24 hour delivery is perferred

SYPHILIS SEROLOGY

Reason For Test

○ Treatment Control (VDRL only, Syphilis already confirmed)

○ Prenatal (Screen due to pregnancy)

○ Premarital State _____ (Required for Marriage LIcense)

○ Diagnostic/Screen (VDRL as screen, if reactive TPPA will be performed for confirmation

○ Reference (VDRL and TPPA performed, Clinical history indicative of Syphilis)

SYMPTOMS

○ NO ○ YES _____

(If yes, list symptoms. Check REFERENCE)

PREVIOUS TEST RESULT: (Please list any previous test results pertaining to specimen submission)

○ VDRL_____ ○RPR_____ ○OTHER_____

HIV

TYPE OF TEST REQUESTED: ○ ELISA ○ WESTERN BLOT

PREVIOUS HIV TEST DONE? ○ YES ○ NO ○ DON'T KNOW ○ DECLINED

IF YES, TYPE OF TEST DONE: ○ Conventional ○ Rapid ○ Other_____

SAMPLE TYPE: ○ Blood-Finger Stick ○ Blood - Venipuncture ○ Blood Spot ○ Oral Mucosal Transudate ○ Other_____

RESULT: ○ Positive ○ Negative ○ Preliminary Positive ○ Indeterminant ○ Don't Know ○ Declined ○ Not Asked

HAS A PREVIOUS SPECIMEN ON THIS PATIENT BEEN TESTED AT THE STATE LAB?

○ YES ○ NO STATE LAB NUMBER _____

FOR PHL USE ONLY

Date/Time Reported:

DOH 302-013 (01/2007)